

Furthermore I would suggest that to label our Victorian asylas as "workhouses" is far more ludicrous and inaccurate than our intention to address a public health issue which even stripped of the "debris" has to my knowledge no moral overtones whatsoever, and if Professor Thompson re-reads my paper he would see that we are well aware that modern and well financed facilities must be provided for all long-stay patients irrespective of aetiology.

Professor Thompson can indeed take comfort that my proposals have little chance of finding favour as in fact the Secretary of State for Health, Kenneth Clarke, delivered a written reply to a Parliamentary Question to Chris Butler, MP who raised the issue of my memorandum during a debate in the House of Commons on the passage of the NHS and Community Care Bill. In essence the Department of Health having respectfully considered the issue I attempted to address (in spite of any inaccuracies or mistakes we may have made!) has decided that the way ahead for both the functionally psychiatrically ill as well as the AIDS dementia population lies in providing community care facilities and therefore the closure programme of the long-stay hospitals is to continue unabated.

Although I take full cognisance of other models of care for AIDS dementia which are equally correct if properly implemented and funded, I would maintain the validity and usefulness of debating the need for a traditional institutional role model, given that until recently the AIDS prevalence figures were far more alarming than the more recent downwardly revised predictions and given the propensity for all governments to restrict NHS financing wherever possible. It may be interesting for Professor Thompson to note that not all authorities are quite as belittling on this issue.

Professor Raphael, from Queensland, Australia, has raised the issue of making psychiatric institutional care provisions for AIDS dementia. I will quote from the 3rd National Conference on AIDS from Hobart, Tasmania, Australia. In session 9 he quotes the frequency of occurrence of the AIDS dementia complex as ranging from 35% to 87% in AIDS patients as evidenced by the 'Report of the Consultation on the Neuropsychiatric Aspects of HIV Infection', Geneva, March 1988, WHO, which also states "The extent to which AIDS dementia patients can be cared for at home is debatable and it may be necessary to plan for long-term in-patient care". Professor Raphael goes on to say "In-patient services for those with delirium and dementia are also required with the utilisation of special units also a possibility. Other psychiatric morbidity such as major psychoses may require in-patient care. Physical facilities to deal with these, as well as well-trained staff and the development of special skill all need to be taken into account as service implications.

Staff concerns about the nature of disturbed behaviour in HIV infected patients such as poor impulse control, sexual acting out or biting, all perhaps with risk of spreading infection to other patients or staff, need to be provided for. Special sensitivity is also required from the staff in view of the degree to which insight is preserved. At the present stage major implications rest with education in both the nature and diagnosis of such conditions and their management. And, depending on the extent of the epidemic, special facilities may need to be developed".

It would be interesting to know if any other of the *Bulletin* readers have any further views or information to shed on this major public health issue.

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Audit of admissions for alcohol detoxification

DEAR SIRS

We were interested to see that the College now expects trainees for the MRCPsych to have experience of medical audit (*Psychiatric Bulletin*, February 1990, 14, 116). We report a prospective audit of in-patient detoxification in West Berkshire Health District, where 200 deaths and 6000 GP consultations in a population of 454,000 were attributable to alcohol misuse in 1987. The district has a community team and an out-patient clinic for people with alcohol problems. Patients who need admission for detoxification go to acute wards in a general psychiatric hospital, where we conducted the study.

We included all patients who had primary diagnoses of alcohol dependence syndrome and were admitted directly from the community for planned detoxification between May 1988 and January 1989. On admission a 14-point questionnaire was used to record social and drinking histories and to confirm the diagnosis of alcohol dependence syndrome. Presence of withdrawal symptoms was checked with a self-assessment questionnaire, based on the Selected Severity Assessment Scale (SSA) (Gross *et al*, 1973), but modified to include questions on disturbance of mood and craving for alcohol.

Just before discharge, even if unplanned, we interviewed patients again and recorded whether they had completed treatment, whether they thought that follow-up arrangements had been made, and what they intended to do about drinking, accommodation, and employment on leaving hospital. Follow-up plans mentioned by ward doctors in their discharge letters to general practitioners, and actual follow-up within six months as entered in hospital and clinic

case notes, were recorded as formal performance indicators.

Hospital In-patient Episode (HIPE) computerised data for the preceding eight months had shown that 52 patients had been admitted for detoxification from alcohol: we hoped to study a similar number. But daily contact with the admission wards yielded only 25 patients during the study period, one of whom refused to participate. Fourteen (57%) were on the waiting list for between two days and six months (median two weeks); the other ten were admitted on the day of referral. Ten were referred by general practitioners, nine by the district out-patient clinic for alcohol misusers, three by general psychiatrists, one by Alcoholics Anonymous and one by employment health services.

In common with users of specialist alcohol treatment units (Hore & Smith, 1981), the patients we studied were mostly middle-aged men with stable employment records and unstable personal relationships. Eighteen (75%) were men, mean age 38.2 years (range 26–58), and six were women, mean age 33.7 (range 21–50). Fourteen (61%) were employed, seven (43%) had suffered marital breakdown, and twenty (87%) had had previous treatment for alcohol problems. Fourteen patients (60%) had a family history of alcohol misuse. There were 21 regular drinkers who consumed a mean of 26 units of alcohol a day (range 10–75 units), and three binge drinkers. Seven patients were concurrently misusing illicit drugs, four others were admitted and discharged taking prescribed benzodiazepines. All patients were withdrawing from alcohol on admission. Two had had delirium tremens in the past but none experienced this syndrome or withdrawal fits during the study. Treatment regimens of chlormethiazole or chlordiazepoxide were used for detoxification, with chloral hydrate or temazepam for insomnia. Vitamin supplements were also given. Detoxification was not combined with any other specific treatments such as structured activity programmes or counselling sessions, but some patients attended local meetings of Alcoholics Anonymous.

Patients were discharged after a mean of seven days (range 2–14), 20 (87%) of them without experiencing any drug-free days. Six said that they had not been offered any follow-up. Eighteen thought that specific follow-up had been arranged but the discharge letters of only 12 mentioned any, and only seven patients (34% of the total sample) actually attended their appointments. This discrepancy between patients' expectations of follow-up and plans described in discharge letters may reflect misinterpretation of advice, poor communication between staff and patients or between ward doctors and GPs, or general ignorance about the functioning and range of community alcohol services. It would be interesting to know why some patients were not

offered follow-up and why others did not comply with it. Other data obtained on discharge were too varied to show any trends.

A retrospective review of HIPE data at the end of the study showed 39 patients as suffering from "alcohol withdrawal syndrome", of whom we had studied 20. Of the 19 patients not studied, we had excluded nine because they had other primary problems (four were suicidal, three were clinically depressed, and two had serious physical complications of alcohol misuse). One who would have been eligible according to his casenotes discharged himself before we could interview him. We missed nine of these patients, but included five others who were not mentioned at all in the HIPE data, and overall saw 73% of eligible patients. Our reliance on these records to choose a reasonable period of study was misguided because some admissions were not recorded on the hospital computer and some were misclassified.

We were disappointed that the number of patients precluded statistical analysis, but even a small study such as this can show where improvements are needed. We hope that we may have stimulated more detailed assessment of detoxification services in this district, which may, in turn lead to change. The real value of audit lies in "closing the loop" – identifying deficiencies, making changes, and then showing that those changes make the service more effective.

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Code of Practice: Section 118 of the Mental Health Act 1983

DEAR SIRS

The Draft Code of Practice laid before Parliament on 5 December 1989 is a very welcome document, clarifying many issues and providing useful guidance. However, I consider that there are a number of deficiencies, particularly in relation to the use of the Mental Health Act in the General Hospital setting.

In Chapter 8, Doctors Holding Power (Section 5(2)), paragraph 8.4 states, "an informal in-patient, for the purpose of this section, is one who has understood and accepted the offer of a bed, who has freely